

NSAID claim, 78% had a claim for a Cox-2, and individuals with CV risk were *more likely* than those at lower risk to have a Cox-2 claim (81% vs. 77%, $p < 0.0001$). As of December 31, 2004, 36% of continuing Cox-2 users had a pharmaceutical marker suggesting significant cardiovascular risk. **CONCLUSION:** As of December, 2004, most recent Cox-2 users with ongoing prescription NSAID use continued using Cox-2s rather than switching to nNSAIDs, and individuals with cardiovascular risk were *more likely* than those at lower risk to continue Cox-2 use. Subsequent analyses will continue to track utilization in this cohort of recent Cox-2 users.

PAR2

THE IMPACT OF SPECIALTY CARE ON THE UTILIZATION OF NEW DRUGS: THE CASE OF COX-2 SELECTIVE INHIBITORS

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OBJECTIVES: To compare the prescribing trends of traditional and COX-2 selective NSAIDs by different physician specialties. We also contrasted the appropriateness of NSAID medication use between physician specialties by comparing prescribing data to a clinically accepted therapeutic guideline on the appropriate use of these medications. **METHODS:** We conducted a retrospective cohort study using pharmacy claims and clinical data on 43,936 adult patients enrolled with an IPA of a midwestern University-associated managed care plan. We identified continuously enrolled managed care members who filled a new prescription for NSAID or NSAID combination from 1999–2002 on a chronic-use basis. **RESULTS:** In total, 1576 patients were started on a traditional NSAID or a COX-2 inhibitor. Primary care patients were younger and less likely to have comorbid conditions. Overall, COX-2 use was two times greater among patients seen by specialists compared to patients seen by PCPs. Use and appropriateness patterns between the specialties were similar over the time course of the analysis. Multivariate logistic regression showed that history of rheumatoid arthritis, osteoarthritis, generalized musculoskeletal pain, or a serious gastrointestinal complication were associated with increased likelihood of being prescribed a COX-2 inhibitor and being placed on therapy considered inappropriate. History of coronary artery disease and patient age were associated with an increased risk of receiving inappropriate therapy. **CONCLUSION:** In addition to prescribing COX-2 inhibitors at twice the rate of PCPs, specialists were less compliant with appropriate use guidelines that considered comorbidities. Overall compliance with appropriate use guidelines was 62%, with PCPs 67% and specialists 49%. Using this drug class as a model for physician adoption of new therapeutic agents, specialists were observed to be more likely to use new drugs, despite the lack of clinical scenarios supporting their use over traditional therapies. Education and interventions to promote appropriate prescribing should target both PCPs and specialists.

PAR3

TESTING THE BMJ CHECKLIST AS A QUALITY ASSESSMENT TOOL FOR ECONOMIC EVALUATIONS

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OBJECTIVES: Several checklists have been proposed for assessing the methodological quality of economic evaluations. However, there is limited literature on the use of such checklists. The purpose of this study was to assess the feasibility and reliability of a well-known checklist as a quality assessment tool.

METHODS: Five experienced health economists applied the *BMJ* checklist, a 35-item questionnaire, to 12 model-based economic evaluations of cyclooxygenase-2 (COX-2) inhibitors. Overall quality of the studies was assessed by measuring the number of positive answers to the questions. **RESULTS:** The five assessors were able to apply the checklist to all 12 studies. The checklist was able to discriminate among the 12 studies, with the total number of positive answers per study ranging from 87 to 132. Although there was a high level of agreement among the assessors' overall scores for the 12 studies, there was considerable disagreement on specific questions, with 100% agreement among all 5 assessors in only 168/420 (35 × 12) possible instances. Often, disagreements occurred for seemingly factual questions (example: Are details of currency or price adjustments for inflation or currency conversion given?). Also, there was a strong relationship between the overall study quality score of the studies and the level of agreement among the assessors. This reflected the fact that quality of study reporting is the main focus of the *BMJ* checklist, rather than the underlying methodological quality of the studies. Even given this focus, it was felt that additional questions related to drug dosing and cost as well as main model parameters should be added to the checklist. **CONCLUSIONS:** The checklist could discriminate among studies, but focussed mainly on the quality of reporting rather than the methodological quality of studies. More study is required of the purpose, feasibility, and reliability of the various methodological checklists.

ARTHRITIS—Other

PAR4

A REVIEW OF TOTAL COST BURDEN OF FIBROMYALGIA

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OBJECTIVE: To characterize the burden of illness of fibromyalgia to employers, insurers, and society. **METHODS:** Two databases were searched, Medline and Healthstar, limited to English language and years 1990–2004. Key search words included fibromyalgia, cost, economics, employment, productivity and disability. Articles were selected that reported utilization of health care resources characterized by either indirect or direct costs. The total cost of fibromyalgia and contributing cost drivers were determined; costs were compared to other diseases. **RESULTS:** A total of 12 articles were reviewed for cost and five of these reported productivity cost. The estimated annual total cost per patient was \$5163–\$11,548 for employers, \$2274–\$9374 for insurers and \$3534.84 for society. Direct costs included: inpatient, outpatient, office visits, medications, alternative medicine, diagnostic tests, lab work and emergency room visits. Indirect costs included: absenteeism, presenteeism, work loss and disability. Productivity loss, medical care and prescriptions were the major determinants of costs to employers. Insurer costs were driven by inpatient care, medications and outpatient visits. Societal costs were driven by health care procedures and productivity impairments. Productivity costs were accountable for 26%–54% of the total cost to employers, and were most often measured by disability and time off work. Only one abstract was identified that measured productivity in FMS patients using a patient-reported measure. **CONCLUSION:** Fibromyalgia is a costly condition; with cost drivers varying by payor type. Productivity is a significant cost driver that should be considered to capture the full burden of fibromyalgia to both the employer and society. Most studies assessing productivity